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Flourishing in Health Care

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Abstract

The purpose of this paper is to offer an account of 'flourishing' that is relevant to health care provision, both in terms of the flourishing of the individual patient and carer, and in terms of the flourishing of the caring institution. It is argued that, unlike related concepts such as 'happiness', 'well-being' or 'quality of life', 'flourishing' uniquely has the power to capture the importance of the vulnerability of human being. Drawing on the likes of Heidegger and Nussbaum, it is argued that humans are at once beings who are autonomous and thereby capable of making sense of their lives, but also subject to the contingencies of their bodies and environments. To flourish requires that one engages, imaginatively and creatively, with that contingencies. The experience of illness, highlighting the vulnerability of the human being, thereby becomes an important experience, stimulating reflection in order to make sense of one's life as a narrative. To flourish, it is argued, is to tell a story of one's life, realistically engaging with vulnerability and suffering, and thus creating a framework through which one can meaningfully and constructively go on with one's life.

Key words: Vulnerability; narrative; well-being; happiness; Heidegger; Nussbaum; MacIntyre.

Introduction

This paper explores the role that the concept of 'flourishing' might play in understanding and evaluating health care. Our aim is not to provide an all-encompassing account of human flourishing, but rather to identify what it might mean to flourish as a patient, a carer, and indeed as a caring institution. While many concepts have been employed in an attempt to capture, even to measure, the desirable outcomes of health care provision, such as 'well-being', 'quality of life', or 'coping', we will argue that the concept of 'flourishing' is uniquely appropriate, because it grasps the struggle and challenge faced by vulnerable patients and indeed by carers, who themselves may be burdened and stressed by the demands of caring. It is typically assumed that to flourish,

a person must act in accord with their nature (Trigg 2005, p. 8). It will be argued that a rigorously articulated conception of 'flourishing' responds to a vulnerability that is inherent to human nature, and thus to the challenge that such vulnerability poses, especially in the context of illness and disease, for anyone striving to live well. Thus to flourish can be neither a transitory state nor mental condition, as say happiness might, nor a final goal or telos. Flourishing rather characterises a life or an extending period of a life, and is an active and ongoing struggle to maintain meaning and purpose in the face of adversity, rather than the final achievement of a stable state of contentment. As such, flourishing requires not merely material aid to alleviate the suffering engendered by, say, injury and disease, but also narrative resources through which the one burdened can make sense of their lives, and thus go on coherently, as patient or carer.

Flourishing and Vulnerability

Many arguments in philosophy, ethics and bioethics focus upon the inherent vulnerability of the human being. Thus, philosophers as diverse as Martin Heidegger (1962), Martha Nussbaum (2001), and Deryck Beyleveld and Roger Brownsword (2001) have explored, in different ways, this aspect of what it is to be human.

Heidegger's analysis of what it is to be human, captured in his term *Dasein* (1962, p. 27), focuses around the question of human mortality, which he terms 'being-towards-death' (pp. 279ff). Humans are beings that are not merely mortal, but are uniquely aware of their own mortality. To live authentically is to live in the face of this knowledge, and not to deny it. Yet more profoundly, Heidegger's analysis of *Dasein* focuses on the finitude of human existence. In using the German term *Dasein* (that simply means 'existence' and as such had a quasi-technical usage in the philosophies of Leibniz and Kant) Heidegger tries to capture two qualities of human nature. On one side humans are merely 'there' (*Da*), contingent creatures, and as such like any other animal, subject to the variability of our physical environment and the accident of our genetics. Yet, as being (*Sein*), our 'Being is an issue for' us (p. 32). This is to say that humans worry about what their existence means, and thus how they ought to

live their lives. Crucially, they have the capacity for autonomous choice, and this moves them beyond a mere animal subservience to their environment or physical body. The irony of the human condition is thus that we simultaneously have imagination, and the capacity to conjure an almost limitless array of possibilities for ourselves, and yet finite bodies and finite time. It is at this everyday level that 'being towards death' has its greatest purchase. For in every choice a person makes, they rule out and potentially close off a thousand more. In the context of the present discussion, disease and injury impose even greater limitations. Injury and disease emphasise the contingency of a person's environment and body. The experience of illness is the experience of human finitude (and ultimately mortality); as such it demands an authentic response that acknowledges finitude as such. This, we will argue, is the first step towards flourishing as a patient.

Martha Nussbaum appeals to ancient Greek literature and ethics to correct the over-emphasis that modern Kantianism has placed upon human autonomy and rationality (2001, pp. 4-5). In Heideggerian terms, Kantian ethics focuses more or less exclusively upon *Sein* (and thus choice) as opposed to *Da* (and contingency or luck). In the context of health care this Kantianism is reflected in the emphasis that the first wave of bioethics placed upon autonomy, for example in championing patient choice and patient rights. While this was an important move in challenging medical paternalism, it came at the cost of neglecting the very condition of patient-hood. Disease and injury inflict an incompetence that curtails, to a greater or lesser degree, one's ability to make rational and thus autonomous choices.

Nussbaum argues that, in contrast to modern Kantianism, the ancient Greek poets find in human being something akin to a plant (and in a metaphor from Pindar, a vine (2001, p. 1)). As such, the individual human is the product of the conditions within which it grows and the actions of those who cultivate it. The human being is vulnerable to contingency or luck. Further, Nussbaum suggests that there lies in this very vulnerability something of the beauty of human existence. The vulnerable creature differs in its value from the impermeable hardness of the gem stone (p. 2). The Kantian denial of vulnerability is thus one sided, precisely in its failure to recognise the value and beauty of that vulnerability. Yet there is a truth in Kantianism, and one that is articulated for

the Greeks by Plato. Humans do indeed aspire to a certain form of invulnerability, and do so through the celebration of rational and self-sufficient choice. Plato offers the example of Glaucon, who Socrates leads to a love of mathematics. Such choice seems to cleanse the human of the “barnacles” and the “seaweed” of passion, the “many stony and wild things that have been encrusted all over it” (2001, p. 5 [citing Plato’s *Republic*, 612A]). The tension between vulnerability and autonomy thereby becomes the crucial context in which the question of how the human being should live its life, and thus what goods it should choose, must be made. Again, it is our contention that in the face of disease and injury this tension becomes most severe and the problem of the good life, and thus how to flourish, more perplexing and elusive.

Beyleveld and Brownsword have offered an account of dignity that recognises human vulnerability (2001, see especially pp. 114-117). Accounts of dignity are frequently grounded in an emphasis on autonomy (again, perhaps most influentially, from the Kantian tradition). On such an account, to act with dignity is to act autonomously and rationally. The application of such an account in the context of health care risks failing to recognise the routine incapacity of the patient to make rational decisions. While advocates or proxies may make rational decisions on behalf of the patient who lacks autonomy, the general thrust of the argument tends to be to work to the restoration of the patient’s autonomy, and thus to their empowerment. Beyleveld and Brownsword challenge this as a one-sided account. Dignity, for them, is a quality of human behaviour, but a quality that is expressed in the face of contingency and vulnerability, rather than being the pure realisation of rational autonomy. Dignity is realised as much through restraint, restricting and guiding the actions of the vulnerable and incompetent patient, preventing them from behaving in an undignified manner, as it is in the empowerment of that person to act freely.

Their argument works, crucially, by substituting the concept of autonomy with that of agency. While autonomy suggests invulnerability (and in Nussbaum’s terms, the purity of Glaucon’s choice), agency is characterised by a recognition, firstly, that agents do not always act morally, and secondly that agents recognise that they may be harmed (either by other agents or by causal factors). Agency thus embraces precisely the self-awareness of finitude and

mortality analysed by Heidegger. The agent may choose to act in ways that compromise their dignity, and Beyleveld and Brownsword's favoured example is that of Manuel Wackenheim, a dwarf who argued that he had the right to be used in Dwarf throwing competitions – a choice that seems to surrender his dignity as a human being (2001, pp. 25-7). Dignity thereby comes to be seen, not as a clearly defined set of behaviours or rights, but rather as something that is continually negotiated and contested, between the individual's assertion of their desire to act freely in a certain way, pursuing certain ends that they personally regard as good, and a socially accepted conception of the good life of the human being. If there is a dignity in accepting and responding creatively to the immorality of others and contingency of the agent's body and environment, then there is also a dignity in the agent's response to the social (moral and legal) restraints placed upon them.

To flourish may be understood as acting with dignity, in something akin to Beyleveld and Brownsword's articulation of the concept. Agents flourish and do so precisely because they lack full autonomy. Yet we would argue that the concept of flourishing can offer a richer account than that of dignity, not least in that it is more obviously sundered from the Kantian stress on autonomy. Specifically in the context of healthcare, flourishing does not make demands for rights, or even the acceptance legal restraints. It is rather, we will argue, a way of finding resources to make sense of the contingencies of disease and injury, and thus to know how to go on, as an agent acting meaningfully, in the face of vulnerability.

Flourishing and Psychological States

Flourishing may appear to be a superfluous additional concept in the armoury of the bioethicist. In that a flourishing life implies a successful one, and one that is recognised as being successful by the person who lives it, it may be suggested that flourishing is reducible to such psychological categories as happiness, well-being or quality of life. We would argue that none of these terms capture the depth of flourishing.

While happiness plays an important role in utilitarian arguments, there is a fundamental difference between a person being happy at any given moment

and that person having lived a happy life. A happy life may be understood as a life that has more happy moments than unhappy ones (or at least, a higher intensity of happiness than unhappiness), and we would suggest that this is the basic utilitarian understanding. Conversely, a happy life may be one that is happy as a whole. This is a more complex and nuanced understanding, and we would suggest, one that begins to establish something fundamental to what it means to flourish.

This may be explored further by considering the example of the Lotus Eaters from Homer's *Odyssey* (Bk IX: lines 64-104). While Odysseus strives to get home, his crew stumble across the isle of the Lotus Eaters. The fruit of the Lotus is a narcotic. The Lotus Eaters are happy (and indeed safe from the perils of the voyage home), and yet, at least from Odysseus' perspective, theirs will not be a happy life. He drags his crew, kicking and screaming, back to the ships. The intuition expressed in this story suggests, primarily, that there may be sources of happiness that are inappropriate, and inappropriate precisely because they do not cohere with the fundamental demands of human nature. Narcotic happiness is a renunciation, and not a fulfilment, of what it is to be human. As such, certain forms of happiness are at odds with a flourishing life. (Mill's distinction between higher and lower pleasures strives to capture something of this intuition (2002, ch 2).) Yet more subtly, the story suggests that the life of the Lotus Eaters falls short because it is a life of immediate gratification, and as such a life without structure or development. While Odysseus suffers hardships and dangers on his journey, it is a quest that, if successful, will come to a meaningful culmination. Even if unsuccessful, the goal of home makes the actions performed on the journey meaningful. In the context of the quest for home, choices can always be made as how to go on. Meaning thus trumps mere happiness in a fulfilled and thus flourishing life.

The concept of 'well-being' is typically articulated in a more sophisticated fashion than is 'happiness' (Griffin 1986), not least in recognising that well-being is not merely that which gives personal or material satisfaction, but that genuine well-being has a moral component. Further, well-being is understood as both the condition of a good life and the goal towards which that life aspires. Precisely in that well-being thereby suggests striving towards some goal, it entails a structuring of experience over a whole lifetime, and not the

mere aggregation of separate moments of happiness. We would, nevertheless, argue that well-being typically lacks an appropriate sensitivity to the vulnerability of the human being, and particularly to that of the patient. Well-being, for example as an interpretation of Aristotle's *eudaimonia*, suggests that material comfort is one of its necessary, albeit not sufficient, conditions. This entails that well-being cannot be enjoyed in a condition of poverty. The moral weight of well-being, as a practical claim, may thus rest in the demand that all have a right to appropriate material resources in order to have the possibility of well-being. Rawls political philosophy, and its focus on primary goods (Rawls 1971), may be so read. If this is an appropriate interpretation of well-being, it entails that the ill person cannot flourish. The patient is a person who has had well-being denied them, and the task of the medical system is to restore the material conditions (such as bodily health or at least appropriate aids and prosthetics) necessary to well-being. Chronic and incurable diseases pose a fundamental challenge to any such view.

Finally, the more specifically medical concept of 'quality of life' may be seen also to have certain affinities with flourishing. The quality of life movement sought to capture the patient's subjective experience of health care, and thereby to offer an evaluation of the success of medical interventions that is complementary to the more objective physiological measures (Bowling 2004). The more sophisticated psychometric instruments currently in use do much, not merely to measure and quantify the subjective experience of health care interventions, but also to allow an understanding of the importance of health to the patient. The patient's experience will be measured over a series of dimensions, allowing the impact of illness upon, for example, the patient's social functioning, family life, emotional life, and leisure activities, to be recorded. The quality of life instrument thus says much about the vulnerability of the patient, and the degree to which illness impairs the patient's sense of well-being. Yet the initial implication here is that the patient is the passive victim of disease, injury and disability (all of which reduce quality of life) and the passive recipient of medical treatments (that ideally enhance quality of life).

There is here a hint of something more subtle (see Bowling 2004, pp. 160-2). The patient's quality of life may vary, not simply as a function of the severity of

the medical condition or efficacy of the treatment, but also as their expectations and understanding of the condition changes. Thus, to take a relatively crude example, the initial fall in quality of life caused by paralysis is typically reversed, even if the condition is permanent, over the period of a year. The patient becomes used to their condition, and modifies their expectations and goals appropriately. They flourish for they come to re-identify themselves. They cease to be a failed able-bodied person, and instead become a successful person with disabilities. The crucial challenge, and we would suggest one that the concepts of happiness and well-being fail to meet, is thus to see the patient not as a failed healthy person (see Callinas, this issue). A patient may flourish as a patient if they strive to experience and practice their life as a structured and thus meaningful whole, despite the absence of certain material conditions of well-being.

Flourishing and Narrative

Disease and injury are, most fundamentally, abnormalities in the functioning of the human body. Through the disruption of the body's capacities, the person's life is disturbed. While ill, normal activities have, typically, to be suspended or curtailed. The ill person may be unable to work, to care for their family and to enjoy their leisure, or at least the ease and facility with which they did those things while healthy is significantly limited. This is precisely that with which the measurement of quality of life concerns itself. The embodied nature of illness entails that attempts to repair physical damage, or to compensate for it (e.g. through the application of prostheses), and thus to restore the material conditions of well-being, are vital. However, if such technological interventions are the only resource available to the medical service, and indeed the only resource upon which the patient can call, then, as noted above, it may be argued that the patient, while under treatment, has no well-being (or at least, the well-being is curtailed proportionately to the severity of the illness and burden of treatment experienced). This might suggest, not merely that acutely ill patients, but also that the chronically ill and the incurable cannot flourish.

While acute illness may disrupt a portion of a life (so allowing for well-being and a high quality of life both before and after the illness), chronic illness may disrupt a life as a whole. Consider a woman who, while wanting to start a family, has made the decision to postpone pregnancy and motherhood until her career is established, and she can thereby offer a secure environment for her family. The woman has a clear understanding of the purpose of her life as a whole, and has made rational decisions as to how to achieve that purpose. However, the human is a plant as well as an autonomous decision-maker – Heidegger's *Da* as well as *Sein*. If the woman was to succumb to a disease that, for its successful treatment, required a hysterectomy, and this before she has realised the intention of having a child, then the rationally chosen purpose of her life is rendered null. The illness disrupts her life as whole, potentially rendering that life meaningless. The point is not merely that her plan for the future, to have a family, can no longer be realised (and thus the meaning and purpose of this future life becomes profoundly ambiguous), but also that the past time spent establishing a career, and thus material security for her family, is now transformed into time wasted. The fleeting opportunity to begin a family has been squandered.

If the woman cannot come to terms with her illness and its consequences, then hers will be a life that does not flourish. The exact nature of a failure to flourish is significant. In this context a failure to flourish may be rooted in a resignation to the situation or a repression of negative emotions. Resignation entails assuming that nothing can be done. It focuses on the material conditions of well-being, and the fact that there is no further technological intervention available to remedy the situation. As such, it entails a conception of the human being as a mere plant, or passive *Da*, the fate of which is dependent wholly upon the technological ingenuity of others and the causal influence of the material world. Repression, and thus the denial that there is a problem, focuses wholly and rather perversely on autonomy, and the activity of *Sein*. It entails a refusal to acknowledge that there is a material problem. The human being rises above the material, and the materiality and contingency of their own body, but only in a self-deceptive assertion of autonomy. The two attitudes are inauthentic. This begins to suggest, we would argue, that flourishing proper requires an appropriate and realistic acknowledgement of the material conditions of suffering, but also an awareness and evocation of

the human capacity to discover new purposes, and thus to re-imagine their lives. Flourishing lies in the ability to tell a meaningful story about one's life, and to use that story as a foundation from which one can go on.

The work of Alasdair MacIntyre provides an important clue to the analysis of a narrative theory of flourishing. My interest is less in his account of the virtues than in his complementary narrative theory (2007, pp. 204-225). Part of MacIntyre's complaint against modern society is that its moral culture and social organisation lead to the fragmentation of individual lives (pp. 204-5). People occupy multiple social roles. Values and goals professed, and even demeanour, in the work place may be significantly different to those of the home and the family, or with friends in leisure-time. This is also the problem of the cruder utilitarian analysis of happiness, precisely insofar as it offers merely an aggregate of isolated psychological experiences, lacking unity. For present purposes, this fragmentation is manifest in illness. While in what Talcott Parsons famously termed the 'sick role' (1991, pp. 294-5) the patient is a different person to their healthy-self. The very notion of the sick role, as a transitory hiatus from normality, discourages any attempt to integrate the deviant experience of illness into the rest of one's life.

MacIntyre argues that an action can only be meaningful if it is understood in the context of a broader life story (2007, p. 218). The movements of a man digging have the most minimal meaning until the context is fleshed out. Thus, there is a difference between digging in a garden and in a field; there is a difference if the digger is a self-motivated gardener or a man striving to please his wife or doctor, by taking healthy exercise. The commitment to healthy exercise itself may no doubt fall into a broader story of a health scare or a family history of heart trouble (and so on). This challenge of interpreting an action is not merely one for the observer. It is a challenge for agents themselves. Without the context of a story, and thus the sense of oneself as a character within that story, where this character has goals and a sense of who they are striving to be, the choice of one's next action, and thus decisions as to how to go on, becomes arbitrary. Choice of action depends upon the consequences that the action has, specifically, for the person I think that I am. The fragmentation of modern life is thus overcome through a quest for narrative unity.

It may be noted that MacIntyre places great emphasis on the notion of a quest: 'The unity of a human life is the unity of a narrative quest' (2007, p. 219). A quest, MacIntyre argues, entails a conception of a goal or telos towards which one is moving, but that this goal is not fully defined until it is discovered. Here MacIntyre reinforces a criticism he makes of Aristotle's account of the virtues. Aristotle can give a highly specific and seemingly universal account of the virtues, understood as the excellences that allow one to achieve one's goal, precisely because he has a definite conception of what the goal of human life is, grounded in a metaphysically account of what it is to be human. MacIntyre's historically sensitive reply is that the conception of what it is to be human, and thus what the telos of human life is, is reinterpreted in every age and society, and indeed, potentially by each individual in their own lives. This point is relevant to any theory of flourishing. We noted above that it is typically argued that one cannot flourish if one acts against (human) nature. We have therefore proposed, following Heidegger and Nussbaum, a highly minimal view of human nature. Humans are vulnerable, at once plant and autonomous being. In Beyleveld and Brownsword's term, they are agents. To flourish presupposes that this nature is respected, and that the individual is aware that they have both free will and that they are subject to contingency. Yet, within this minimal basis there is vast scope to explore what one's own personal telos and nature might be. Flourishing, we therefore argue, is a quest to discover who one is. While MacIntyre stresses the challenge that the fragmentation of modern life poses to this quest, we rather stress the challenge posed by the contingencies that afflict our choices and autonomy.

Here we wish briefly to return to Beyleveld and Brownsword, in order to note a parallel between their account of dignity and the telos of flourishing outlined above. Beyleveld and Brownsword argue that the individual's own sense of their dignity (and thus the actions they choose, autonomously, to perform) may be at odds with the conceptions of dignity and dignified behaviour held in the wider society. Thus, the dwarf Manuel Wackenheim holds a fundamentally different view of dignified behaviour than does French society. For Beyleveld and Brownsword, in this case at least, the social view should trump the individual's, thereby constraining individual behaviour. In terms of flourishing, this suggests that what the individual regards as a flourishing life may well be at odds with that of their society. In a given case the attribute of flourishing

can be highly contestable. My point is then, following MacIntyre, that there is not a single, metaphysically grounded, definition of flourishing as a telos to which all should aspire. The understanding of flourishing will vary historically and culturally. It will also differ between individuals, so that what it means to flourish is a potential site of conflict and negotiation. Courageous individuals may offer new ways of flourishing that, initially, may not be recognised as such.

To return to the main thread of our argument, the experience of contingency (not least as experienced in disease or injury) that disrupts a life may now be understood as a disruption of the story that patients tell about their lives. It follows that the sort of disruption represented by illness is fundamental to the possibility of flourishing. If a person could lead a trouble-free life, for example by having a happy and secure childhood, effortless success in education and work, a loving partner, successful children and the peaceful death at a good age, it is not clear, on our account, that we could say that they have flourished. Their life may have been happy, but only in the sense that the life of the Lotus Eater is happy. The lack of conscious struggle and adversity, and thus a lack of an overt encounter with one's own vulnerability, entails that there is no stimulus to reflect upon life as a whole. There is no stimulus to tell or re-tell a life story. This happy person can live in the present like the Lotus Eater, or perhaps worse, assuming that they tell a life story, they tell a story that recognises only their autonomy. They tell the story of a 'self-made' man or woman. Acute illness potentially plays an important part in such a life. In acute illness, vulnerability and contingency intrude upon the self-delusion of pure autonomy. While the story of the sick role encourages the person to ignore its significance, separating the experience of illness from that of the 'true' self, more profoundly it can be recognised as the moment at which one has the possibility of recognising the contingency and fortune that underpins even a happy life, and which makes that life possible.

To turn back to the issue of chronic illness, our example of the woman who undergoes a hysterectomy indicates how severe and chronic disease can, unlike acute illness, be undeniable, as it disrupts the sense of who the person is as a whole. As the old story of the woman's life becomes unviable, so too does the character, and thus the personal identity, that lies at the centre of that

story. Without character or story, the woman cannot go on. The narrative framework within which decisions about the appropriateness or otherwise of actions is stripped away. Only the creation of a new story and a new character for herself will resolve this impasse. Such a story is not merely a story of the rest of the woman's life, but also a retelling of the past, so that it ceases to be futile. This is difficult, and is why many fail to flourish, consumed by regrets and recriminations. As the notion of quest highlights, the new story is not something that can simply be imposed, by will, upon one's life. It is, rather, something for which one searches. This search entails practical activity. The story of one's life is a story that is lived. The new character must therefore be embodied. Quests entail experiments and thus failures, as well as successes. The new character and story will not simply emerge in a fruitful cycle of being lived and told, but will have to be re-told and reinterpreted, not least as dead-ends and failures are encountered, but also as new opportunities are recognised.

MacIntyre argues, with some subtlety, that there are different ways in which the story of a life can be told (2007, pp. 212-3). The same events can be narrated as a heroic saga, a tragedy, a romantic comedy and so on. Not all genres are appropriate to all stories, and the flourishing of an individual life will depend significantly upon the way in which that life-story is told. Not all stories have happy endings. To recognise the tragedy of one's life, and to find meaning in that, is different from inauthentic despair or denial (see Edgar 2007). Yet this further suggests that for the patient to flourish, they must have access to appropriate narrative resources. The patient does not exist in isolation. As a social being they draw upon the stories already told to them. Again, even in the creative activity of the imagination, the person, like a plant, is in need of cultivation. The storyteller is no more the isolated and autonomous Kantian individual than is the patient. A lack of sympathetic stories inhibits flourishing. As Frank has argued, if the only story one has available, as a patient, is that of the sick role, then chronic illness is meaningless (1995, pp. 5-6). The sick role tells a story that it is normal to fall ill, follow one's doctor's instructions, and so get better. The dominant story of acute illness, as we have argued, fragments a life. The experience of illness is placed outside of one's supposedly true or authentic story. Chronic illness does not allow either for the happy ending or recovery, or for the

sequestration of illness from the rest of one's life. Chronic illness thus poses relentlessly the challenge that all illness in fact represents. Even acute illness, as we have argued, highlights the truth of our vulnerability (and thus the human nature of which we must take account if we are to flourish). A culture that offers only the superficial story of the sick role, and thus a culture without stories of chronic illness, or a culture that offers only stories that condemn the chronically ill as malingerers or as permanently ineffectual), as Frank argues, entails that the continuation of the illness is experienced as meaningless (for how can one go on, if no action leads to a cure) or worse, as one's own fault. Crucially, it is here that the patient needs to be understood as a character in their own right, and not as a failed healthy person. Yet again, the story of the chronically ill or disabled person may be in a very different genre to that of the seemingly untroubled healthy person, but it may also be a richer story, and thus say much about the vulnerability inherent to all humanity.

Flourishing and Institutions

We have, above, explored the conditions under which it may be said that an individual flourishes. We argue that flourishing requires the agent to recognise their vulnerability and contingency, and to use their imagination and thus their autonomy to engage honestly with that contingency. A flourishing life, taken as a whole, is thus not a life spared contingencies, or even spared mistakes, setbacks and tragedies. It is rather a life that has engaged with and made sense of those contingencies. Chronic illness is typically a sufficient, but not a necessary, stimulus to this engagement. The disruption of the experience of illness prompts reflection upon what it is to be human, and within this context what the purpose of one's own life can be. In flourishing the individual draws upon the resources culturally available to them in order to tell and re-tell the story of their life, and construct and re-construct themselves as the hero of this story.

Flourishing may appear to be a quality of the individual, and indeed it can appear self-centred or egotistical. We argue, however, that the individual is necessarily a social creature. We have suggested above that the attribution of flourishing is always potentially contestable, as social and individual

conceptions of flourishing diverge. Yet, as social beings, we draw upon the culture around us in order to provide templates and models for our own story telling. As story-tellers, our stories overlap and intertwine with those of others. MacIntyre elegantly notes that: 'In my drama, perhaps, I am Hamlet or Iago or at least the swineherd who may yet become a prince, but to you I am only A Gentleman or at best Second Murderer, while you are my Polonius or my Gravedigger, but your own hero' (2007, pp. 213-4). If flourishing is a moral quality, and not merely a prudential one characterised by practical success, then to flourish entails respecting the stories and lives of others, not least through recognising the constraints and demands that those stories place upon us. The stories of others are a significant part of the contingency and luck that shapes us. There is a difference between being a plant that is nourished and cultivated by others and a parasite that wilfully saps the energy of its host.

This reflection may be taken further by suggesting that not merely individuals but also institutions can flourish. Indeed, we would argue more strongly, that the individual is more likely to flourish if they are part of a flourishing institution. Institutions, such as hospitals, GP practices, and even a national health service, have stories told about them, and the members of the institution will tell its story as part of their own. More precisely, the story that one tells of oneself as a member of an institution is in part constituted by the story of the institution, for as an individual the agent adopts a character specified by the institutional story (e.g. nurse, consultant, manager, cleaner, patient). Just as Hamlet is played differently by each actor who takes on the role, so these institutional characters will be played, and their stories told, each in the idiom of the individual. Yet, the flourishing of the institution lies in the dialogue that exists between these different individual stories.

Again, to highlight the nature of institutional flourishing, the nature of a failure to flourish may be considered. Institutions, like individuals, fail to flourish if they are unable to make sense of contingency, and as such are unable to go on. As with the individual, the institution may capitulate in the face of contingency, being overwhelmed by the apparent impossibility of resolution or change, or may retreat into denial. Above we suggested that the source of such failure for the individual lies, not simply in the severity of the contingency they face, but crucially in their capacity to create a story. This capacity relies,

not merely upon their own imagination, but also upon the resources they have available to them in their culture. The lack of appropriate stories (as Frank highlights in the case of chronically ill patients) inhibits the possibility of flourishing. An institution is necessarily composed of its individual members. Thus, in order to flourish it requires individual members who either have the imagination to see the world differently, and to communicate that vision to others, or members who can draw upon, and if necessarily reshape and retell, narrative resources that already exist. An institution will fail to flourish if there are no appropriate stories, or if a single, inappropriate, story dominates. As MacIntyre argues, an institution is in good order when there is an internal argument about the purposes and nature of that institution (2007, p. 222). To the degree to which that debate and sharing of stories is inhibited, be it due to lack of narrative imagination, lack of narrative resources, or perhaps more significantly, an inherent political structure that prevents dialogue and the proposal of alternative narratives, the institution will fail to flourish. Precisely because the story of the institution would thereby be an inauthentic one, in that this story shapes the stories of the characters who make up the institution, so too there is a danger that the personal stories of the institution's members will become inauthentic. They too will fail to flourish, unless they can engage with the failure of the institution as part of the contingency of their own lives. Living and working within a failing institution may be as fundamental a stimulus to the re-telling of one's own life story and the reconstruction of one's own identity and character as is chronic illness.

Concluding Remarks

We have proposed the concept of 'flourishing' as having a richness and precision that allows it, uniquely, to articulate the experience and challenges posed to the patient and their carers. In order to flourish one must recognise and confront the vulnerability that lies at the heart of human nature. As agents, humans are at once subject to contingency and luck, and yet have imagination and freedom of choice and action. The experience of contingency, not least in illness, may proper reflection upon how one, as an individual, deals with that vulnerability. In the narrative account of flourishing that we have offered, this entails understanding oneself as a character in one's own story.

Such a character has certain goals and values. The character will strive to act in a coherent and consistent manner, and thus express a sense of personal identity. The narrative framework, that at once sets goals for one's future and makes sense of the achievements (and failures) of one's past, is the framework within which one can make decisions about how to go on, and thus the framework within which one can act meaningfully.

While not denying the importance of physiological interventions in the treatment of patients, restoring functioning and thus what we have termed the material conditions of flourishing, we have also stressed that patients require appropriate cultural resources in order to make sense of their condition. Without appropriate narrative frameworks, found, for example, in the stories of fellow sufferers, and thus models for one's own sense of character, illness threatens to become meaningless. Such experience of illness renders it a hiatus from ordinary life, in which, as Frank argued, the patient becomes passive (for how are they to decide to act meaningfully) before the demands of the medical process. To understand flourishing as a narrative quest, and crucially a quest that is conducted in co-operation and dialogue with others, is to understand health care, not merely as a technical procedure, but also as a continuing challenge to understand what it is to be a patient, and thus the place that the experience of illness plays in one's life as a whole.

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